Supreme Court, U.S.
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No.

In the

Supreme Court of the United States

SCOTT FALLO AND KASEY FALLO,

Petitioners,

v.

PICCADILLY CAFETERIAS, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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44 pp

QUESTIONS PRESENTED FOR REVIEW

1. Should an analysis of whether to award attorney's fees in ERISA actions include a presumption that the prevailing party recover attorney's fees?

2. Is the five-factor analysis utilized by the Fifth Circuit when determining whether to award attorney's fees to a prevailing party in an ERISA action consistent with the purpose of the fee-shifting statute?

3. Does the use of the five-factor analysis when determining whether to award attorney's fees under ERISA operate to preclude a settling party from receiving an award of attorney's fees?

4. Is a two-year delay in evaluation of claims for benefits legally due under and ERISA claim tantamount to bad faith on the part of a conflicted claims administrator?

5. Is a plan administrator entitled to rely solely on the submissions of a claimant when denying claims or does the administrator have a duty to diligently investigate the claim?

6. Does the failure of a conflicted claims administrator to diligently investigate claims for benefits in a timely matter result in bad faith?

PARTIES TO THE PROCEEDING

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Scott Fallo (Petitioner)

Piccadilly Cafeterias, Inc. (Respondent)

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TABLE OF CONTENTS

QUESTIONS PRESENTED i
PARTIES TO THE PROCEEDINGS ii
TABLE OF CONTENTS iii
TABLE OF AUTHORITIES iv
OPINIONS BELOW 1
JURISDICTION 1
STATUTORY PROVISION INVOLVED 1
STATEMENT OF THE CASE 2
REASONS FOR GRANTING THE WRIT 4
ARGUMENT 5
CONCLUSION 19
APPENDIX
CIRCUIT COURT ORDER (5/1/02) 1a
DISTRICT COURT ORDER (8/16/01) 3a
DISTRICT COURT ORDER (9/26/01) 17a

TABLE OF AUTHORITIES

CASES

ALYESKA PIPELINE SERVICE CO. V. WILDERNESS SOCIETY, 421 U.S. 240, 258-59, 95 S.CT. 1612, 1622, 44 L.ED. 141, 154 (1975).....8

BAETEN V. VAN ESS, 474 F. SUPP. 1324, 1332 (E.D. WIS. 1979).....8

BUGHER V. CONSOLIDATED X-RAY SER. CORP., 705 F. 2D 1426, 1436 (5TH CIR. 1983), CERT. DEN. 105 S.CT. 3524 (1985).....9

DONOVAN V. CUNNINGHAM, 716 F.2D 1455, 1475 (5TH CIR. 1983), CERT. DENIED, 467 U.S. 1251, 104 S.CT. 3533, 82 L.ED.2D 839 (1984).....5

EAVES V. PENN, 587 F.2D 453 (10TH CIR. 1978).....5

FALLO V. PICCADILLY CAFETERIAS, INC., 141 F.3D 580 (5TH CIR. 1998).....8

FIRESTONE TIRE & RUBBER CO. V. BURCH, 489 U.S. 101, 115, 109 S.CT. 948, 956, 103 L.ED. 2D 80 (1989).....7

GIBBS V. GIBBS, 210 F.3D 491, 504 (5TH CIR. 2000).....6

GOODEN V. PROVIDENT LIFE & ACCIDENT INSURANCE CO., 250 F.3D 329, 333 (5TH CIR. 2001).....15

IRON WORKERS LOCAL #272 V. BOWEN, 624 F.2D 1255, 1266 (5TH CIR. 1980).....4, 5, 6

LANDRO V. GLENDENNING MOTORWAYS, INC., 625 F. 2D 1344, 1356 (8TH CIR. 1980).....9

NATIONAL COMPANIES HEALTH BENEFIT PLAN V. ST. JOSEPH'S HOSPITAL OF ATLANTA, INC., 929 F.2D 1558, 1575 (11TH CIR. 1991).....6, 17

NEMOURS & CO., 966 F.2D 1011, 1017 (5TH CIR. 1992)6, 8, 13, 14

PENN V. HOWE-BAKER ENGINEERS, INC., 898 F.2D 1096, 1100 (5TH CIR. 1990) 7

ROIG V. LIMITED LONG TERM DISABILITY PROGRAM, 2000 WL 1176522 (E.D. LA. AUGUST 4, 2000).....18

VEGA V. NATIONAL LIFE INSURANCE SERVICES, 188 F.3D 287, 298 (5TH CIR. 1999) 13, 14

STATUTES

28 USC §1254(1) 1

28 USC §1291 1

29 USC §1001 .....1, 2

29 USC §1132 .....5, 20

29 USC §1132(g)(1) 1, 5

Other AUTHORITIES

MARK HOWARD BERLIND, 71 CORNELL L. REV. 1037 (JULY, 1986).....5

Scott Fallo and Kasey Fallo, Petitioners, by undersigned counsel, under appropriate rules of this Court, request that this Court issue a writ of certiorari to the United States Court of Appeals for the Fifth Circuit.

I. OPINIONS BELOW

The decision of the United States Court of Appeals for the Fifth Circuit dated May 1, 2002 is set forth in the Appendix, p. 1a. The decision on the record from the District Court of the Eastern District of Louisiana dated August 16, 2001 is set forth in the Appendix, p. 3a.

II. JURISDICTION

Subject matter jurisdiction for granting of attorney's fees and costs in an action for health insurance benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is found in the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 USC §1001, et seq.

Subject matter jurisdiction for the United States District Court for the Eastern District of Louisiana is found also in ERISA. Subject matter jurisdiction for the Court of Appeals for the Fifth Circuit was invoked through ERISA and 28 USC §1291.

The jurisdiction of this Court is invoked under 28 USC §1254(1).

III. RELEVANT PROVISIONS INVOLVED

Employee Retirement Income Security Act, 29 USC §1132(g)(1).

> (g) Attorney's fees and costs; awards in actions involving delinquent contributions
>
> (1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action

to either party.

IV. STATEMENT OF THE CASE

A. Course of Proceedings and Disposition in Courts Below

Plaintiffs, Scott Fallo and his wife, Kasey Fallo, filed this action on February 10, 1994, in Louisiana state court against Mr. Fallo's former employer, Piccadilly Cafeterias, Inc. ("Piccadilly"), claiming entitlement to extended health insurance benefits from Piccadilly under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Piccadilly removed the action to the United States District Court for the Eastern District of Louisiana pursuant to that court's federal question jurisdiction since the action involved a controversy arising out of and governed by the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, et seq., and COBRA.

Piccadilly then filed its first Motion for Summary Judgment which was heard on June 14, 1994, the result of which was a judgment partially in Piccadilly's favor dismissing certain portions of the Fallos' claims. The trial court, however, denied a portion of Piccadilly's Motion for Summary Judgment and preserved the Fallos' right to pursue their claim for 11 months of extended health insurance coverage provided by COBRA.

Thereafter, Piccadilly reurged its Motion for Summary Judgment, the result of which was an order dated March 17, 1995, again denying the Motion for Summary Judgment. Piccadilly moved to stay the litigation pending the outcome of a determination by the Social Security Administration of Kasey Fallo's disability, which stay was granted by the trial court.

The Social Security Administration initially denied Mrs. Fallo's application for disability benefits filed in April 1994. The Fallos appealed the denial and the Social Security Administration determined on November 27, 1996, that Kasey Fallo had been disabled between March 1993 and October 1994.

After that decision became final, the Fallos filed a Motion for Summary Judgment asserting their entitlement to the additional 11 months of health insurance coverage provided by COBRA upon the onset of the disability. Piccadilly filed a Cross-Motion for Summary Judgment, denying that the Fallos were entitled to extended benefits alleging the Fallos did not apply to the Social Security Administration for a disability determination until six (6) months after the initial 18 month COBRA coverage period had expired. The trial court denied the Fallos' Motion for Summary Judgment and granted Piccadilly's Cross-Motion on July 29, 1997.

The Fallos appealed to the United States Fifth Circuit Court of Appeals, which reversed the grant of summary judgment in favor of Piccadilly and rendered judgment in favor of the Fallos on the coverage issue on May 29, 1998. The Fifth Circuit held that the Fallos were entitled to rely upon Piccadilly's Summary Plan Description of its health insurance plan, had complied with the requirements of the SPD and were entitled the additional 11 months of extended health insurance coverage they sought. The case was remanded to the district court to determine the amount of benefits that Piccadilly owed the Fallos and the amount of premiums owed by the Fallos for the extended coverage.

B. Statement of Facts Leading to this Petition

Piccadilly, then continued to argue that the premiums due by the Fallos exceeded the benefits payable by Piccadilly, seizing upon a self-serving affidavit it submitted with no evidence to support this position. This argument had continued for over two years, with Piccadilly only delaying its complete analysis of benefits versus premiums.

Finally, the parties settled the benefits and premiums issue a few days before the scheduled trial and the district judge entered a 60-day order of dismissal on March 1, 2001. The settlement amount was $31,580.76 in gross benefits, plus judicial interest, less premiums of $2,667.67 plus judicial interest. The presiding district judge referred the attorney's fees and costs issues to the magistrate judge for findings and recommendation. The Fallos filed a timely motion for

attorney's fees and costs, and the magistrate judge issued a ruling on August 16, 2001, recommending that this Court deny the Motion for Attorney's fees filed by the plaintiffs in this matter based on his analysis of the factors enumerated in Iron Workers Local #272 v. Bowen, 624 F.2d 1255, 1266 (5th Cir. 1980). The district court judge adopted the magistrate's findings and denied the Fallos' Motion for Attorney's Fees and Costs. Petitioners appealed.

On May 1, 2002, the Fifth Circuit affirmed the holding denying the petitioners claim for attorney's fees, holding that the district court's findings by applying the five-factor analysis in Iron Workers were not clearly erroneous nor represented an abuse of the trial court's discretion.

V. REASONS FOR GRANTING WRIT

When determining whether or not attorney's fees are to be awarded to a party in an ERISA action, the Fifth Circuit Court of Appeals utilizes a five-factor test without applying a presumption that a prevailing plaintiff should recover attorney's fees unless special circumstances would render such an award unjust. Such application resulted in its decision in the instant matter whereby the prevailing plaintiff was not awarded attorney's fee, which application is in conflict with the presumption applied by the Second, Eighth and Ninth Circuit Courts of Appeals.

The Fifth Circuit erred in finding that the district court did not abuse its discretion when failing to award attorney's fees to a prevailing plaintiff in an ERISA action. By affording each of the five factor's equal weight, by not considering the conflicts of the administrator-employee, and by not applying a presumption that a prevailing plaintiff should be awarded attorney's fees, the Fifth Circuit rendered a decision that is in direct conflict with the decisions of the Second, Eighth and Ninth Circuits.

The Fifth Circuit's application of the five-factors, without the presumption in favor of the prevailing party, inherently results in the denial of attorney's fees when the prevailing party settles the underlying claim for benefits. The factors concentrate on culpability of the losing party so much

so that a settling party's ability to achieve a fee award is negated.

This Court should grant writ to resolve the disparities between the application of 29 USC §1132 (g)(1) by the various circuits and announce a uniform test for the federal circuit courts of appeals to apply when determining whether or not to award attorney's fees in ERISA actions.[1]

VI. ARGUMENT

A. Law Governing Award of Attorney's Fees and Costs:

ERISA provides that: "[i]n any action under this subchapter ... by a participant, beneficiary or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 USC §1132(g)(1). See also Iron Workers Local # 272 v. Bowers, 624 F.2d 1255, 1266 (5th Cir. 1980). This award reimburses litigants for the cost of counsel, thus reducing if not eliminating one of the major obstacles to filing a lawsuit. However, unlike other fee-shifting statutes, Section 502(g)(1) does not indicate when courts should make an award, and its legislative history provides no guidance. Such an award is purely discretionary, and the district court's decision is reviewed only for abuse of discretion. Donovan v. Cunningham, 716 F.2d 1455, 1475 (5th Cir. 1983), cert. denied, 467 U.S. 1251, 104 S.Ct. 3533, 82 L.Ed.2d 839 (1984).

The judiciary, therefore, created a five-factor test for providing "guidance" as to when an award of attorney's fees is appropriate. The Tenth Circuit first announced the test in Eaves v. Penn, 587 F.2d 453 (10th Cir. 1978), which test was subsequently adopted by the Fifth Circuit in Iron Workers Local # 272 v. Bowen, 624 F.2d 1255, 1266 (5th Cir. 1980). Now nearly every federal circuit has adopted this five-factor test, or a similar one, applying the test on a case-by-case basis. The district courts are to consider a "nuclei of concerns" in

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[1]Discussions throughout this petition regarding the inappropriateness of the five-factor analysis were gleaned from discussions found throughout the law review comment, "Attorney's Fees Under ERISA: When is an Award Appropriate," by Mark Howard Berlind, 71 Cornell L. Rev. 1037 (July, 1986).

deciding whether to award attorneys' fees under ERISA which are: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorneys' fees; (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting in similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions. Salley v. E. I. DuPont de Nemours & Co., 966 F.2d 1011, 1017 (5th Cir. 1992); Iron Workers Local # 272 v. Bowen, 624 F.2d 1255, 1266 (5th Cir. 1980), appeal after remand, 695 F.2d 531 (5th Cir. 1983); National Companies Health Benefit Plan v. St. Joseph's Hospital of Atlanta, Inc., 929 F.2d 1558, 1575 (11th Cir. 1991). However, an explanation as to why they would use or how they developed this five-factor test was never given by the Eaves court or the Iron Workers court.

In addition to the five-factor considerations, some circuits have adopted a presumption that a prevailing party "should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust." In attempting to develop a standard for fee shifting under ERISA, the Second, Eighth and Ninth Circuits hold that a Fees Act approach should apply to ERISA actions thereby creating the presumption. In those circuits, the five factors are formally recited as justification for an almost automatic award to every prevailing party. Several circuits, including the Fifth Circuit, have stated that a proper analysis of the five factors will, in most instances, favor an award of fees to the party which has most substantially prevailed. Gibbs v. Gibbs, 210 F.3d 491, 504 (5th Cir. 2000).

B. **Without a Presumption Favoring the Prevailing Party, Application of the Five-Factor Test in the Instant Case Shows Its Inherent Faults**

If this case had been decided by either the Second, Eighth or Ninth Circuits, the Fallos would have been awarded attorney's fees due to the presumption that a prevailing party obtains an award unless special circumstances would have

rendered such an award unjust. However, the Fifth Circuit does not utilize this presumption. Therefore, because of the inherent problems with the five-factor analysis, specifically its concentration on culpability of the losing party, a prevailing party choosing to settle his claim, like the Fallos, is less likely to be awarded attorney's fees. The fact that the losing party was reasonable in settling the matter negates against any finding of culpability or bad faith. However, if the presumption was applied, the Fallos would have prevailed as no special circumstances making an award unjust were present.

Piccadilly continuously denied the payment of benefits to the Fallos throughout this litigation. This Court held that the denial of benefits "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Burch, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed. 2d 80 (1989). If the plan gives the administrator or fiduciary discretionary authority, then an abuse of discretion standard is applied. Id. In this case, the Piccadilly health plan set forth the discretionary authority of the Plan Administrator.

In applying an abuse of discretion standard, an analysis must be made as to whether the plan administrator acted arbitrarily and capriciously. Penn v. Howe-Baker Engineers, Inc., 898 F.2d 1096, 1100 (5th Cir. 1990). "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is abuse of discretion." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101,115 (1989)(citation omitted).

Piccadilly proclaimed its reasonable stance throughout the litigation citing the fact that its "good faith" interpretation of ERISA was well-founded and was agreed to and adopted by the trial judge through the granting of Piccadilly's Motion for Summary Judgment. That grant of summary judgment, however, was overturned by the Fifth Circuit. Fallo v. Piccadilly Cafeterias, Inc., 141 F.3d 580 (5th

Cir. 1998).

A careful review of the proceedings and record in this matter reveals that Piccadilly had consistently maintained a belligerent position and a steadfast refusal to pay benefits to or on behalf of the Fallos. The actions or inactions of Piccadilly throughout this litigation and its professed reasons therefore constituted arbitrary and capricious behavior tantamount to a clear abuse of discretion, especially since those behaviors were conducted by a conflicted plan administrator. The Fifth Court's approach to this kind of case is a sliding scale standard where the existence of a conflict is a factor to be considered in determining whether the administrator abused its discretion in denying a claim.

Generally courts use the five factors to decide abuse of discretion based upon the information known to the administrator at the time he made the decision. Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1015 (5th Cir. 1992). The administrator can abuse his discretion if he fails to obtain the necessary information in order to make an reasonable and informed decision regarding a claim. Id. An analysis of Piccadilly's actions and inactions clearly shows its culpability and clear abuse of discretion in its denial of the Fallos' claims.

1. *The degree of the losing party's culpability or bad faith*

Under fee-shifting principles, courts may shift fees if bad faith exists, regardless of statutory authority. This Court recognized that equity allows an award of attorney's fees "when the losing party has 'acted in bad faith, vexatiously, wantonly, or for oppressive reasons....' Alyeska Pipeline Service Co. v. Wilderness Society, 421 U.S. 240, 258-59, 95 S.Ct. 1612, 1622, 44 L.Ed. 141, 154 (1975) (Citations omitted). Consideration of a defendant's bad faith is therefore unnecessary with a fee-shifting statute. The Eastern District of Wisconsin modified its application of the Eaves test to exclude any consideration of bad faith, recognizing this unnecessary and superfluous consideration. See Baeten v. Van Ess, 474 F. Supp. 1324, 1332 (E.D. Wis. 1979). See also, Landro v. Glendenning Motorways, Inc., 625 F. 2d 1344, 1356

(8th Cir. 1980) (noting that courts have discretion at common law to award attorney's fees against losing parties who have acted in bad faith and that there is presumption against interpreting statute so as to render it superfluous); Bugher v. Consolidated X-Ray Ser. Corp., 705 F. 2d 1426, 1436 (5th Cir. 1983)(Assessing fees against a party who had acted in bad faith when award was not justifiable under §502(g)(1)), cert. den. 105 S.Ct. 3524 (1985).

This factor is improper because by considering the degree of a party's culpability, the court uses a fee shifting provision as a punitive measure. Further, the fifth factor requiring a consideration of the relative merits of a party's position, also requires an inquiry as to culpability.

Any inquiry into culpability is improper because, as in this case, it suggests and results in the court denying a fee to an otherwise worthy party because the losing party was not culpable. It also negates against conserving judicial resources and settling underlying claims because the reasonableness of the settlement can be and is viewed as nonculpable behavior, thereby preventing a settling party from a fee award. In the instant case, however, although Piccadilly settled the Fallos' underlying claim, its actions throughout the litigation represent culpable behavior. The trial court erred in not considering those actions in light of the fact that the claims administrator was an employee of Piccadilly and thereby conflicted.

Throughout the course of the litigation, Piccadilly's alleged rationale for denial of benefits has changed, with Piccadilly seizing upon the opportunity to assert what appears to be a new legitimate explanation when each previous explanation it offers fails with the courts. Piccadilly has utilized any and every opportunity and any reason it could conjure to avoid paying benefits under the requested extended coverage.

When first notified of Kasey Fallo's disability, Piccadilly conditionally responded that there would be no extension of benefits unless there is a social security finding of disability within 60 days of the expiration of the initial coverage on August 25, 1993: "Mrs. Fallo has sixty (60) days from the date of the discontinuation of coverage to establish

that she is disabled for purposes of social security and therefore entitled to COBRA benefits." Then, Piccadilly changed its mind, returned the Fallos' premium, and unconditionally denied extended coverage. Piccadilly then proceeded to vigorously oppose the Fallos' attempts to obtain coverage throughout this litigation.

As its initial defense, Piccadilly argued that the Fallos were not entitled to extended coverage because at that time a disability determination had not yet been obtained by Kasey Fallo from the Social Security Administration. Piccadilly even obtained a stay of proceedings on the precedent that the determination of the Social Security Administration would be dispositive of the issue: "[I]f Ms. Fallo was in fact disabled, and if the disability is determined to have begun during the eighteen months of COBRA coverage, then she would be entitled to additional coverage." The Fallos relied upon this assertion, foolishly believing that a disability determination by the Social Security Administration would be their last step before obtaining benefits.

When the Social Security Administration ruled in the Fallos' favor regarding Kasey Fallo's disability, Piccadilly still denied extended benefits, contradicting their former representations to this Court and the Fallos that a decision by the Social Security Administration would settle the matter. Piccadilly now began arguing that the failure of the Fallos to obtain the SSA disability determination within 18 months of the qualifying event, i.e. Scott Fallo's termination of employment, was its legitimate reason for denial of benefits. According to Piccadilly, Scott Fallo's employment was terminated in February 1992, and, according to its Plan, a disability determination would have been required by August 25, 1993. Piccadilly pointed out that the Fallos did not even institute this legal action until February of 1994, after which a disability determination was finally obtained.

If Piccadilly had been genuine in their coverage interpretation and had indeed exhibited "good faith,", it would have initially denied the extension for all of the above reasons, i.e., the fact that no disability determination was obtained whatsoever within the requisite time period. This would have forced this Court to rule on the timeliness issue

before the disability determination was obtained, instead of waiting over 18 months only to have Piccadilly deny benefits again, regardless of the results of the Social Security Administration proceedings. However, Piccadilly has engaged in a steadfast denial of coverage for one reason or the other, jumping from reason to reason when one explanation does not suffice as a legitimate basis for denial of benefits. Apparently, Piccadilly expected the Social Security Administration to rule that Kasey Fallo was not disabled which is why they wanted to say the instant proceedings.

Piccadilly even went so far as to claim that even if coverage should have been extended, the amount of premiums due Piccadilly actually exceeded the amount that Piccadilly should be required to pay in claims. In other words, Piccadilly took it upon itself to analyze the claims as submitted by the Fallos, and still denied benefits.

A review of the record shows that Piccadilly was provided with detailed billing as to the amounts of the claims and the reference codes attributed to those treatments. The denial in the affidavit was broad and unexplained as to the cause. Piccadilly took no steps to further investigate the claims by either requesting more complete submissions from the health care providers or the insured, more complete billing from the providers or the insured, complete hospital records, etc. Piccadilly was apparently so convinced of its eventual success in this litigation, that it ignored the submitted claims until the probability arose that the insurance coverage may indeed be extended beyond the initial 18-month period, resulting in the execution of the conflicted claims administrator's self-serving affidavit arguing that premiums exceeded benefits. It was only at that point in time that Piccadilly began claiming incomplete submissions.

Under ordinary administrative practices, the administrator would properly investigate the claims, the charges, and the prognoses of doctors to determine if coverage under the health plan would apply and benefits awarded. Plaintiffs forwarded invoices to defendant as far back as August 31, 1994, the date of their initial responses to Piccadilly's Interrogatories and Requests for Production, which identified all care givers and the amounts of benefits

claimed under the policy. Apparently, the charges were summarily dismissed based upon Piccadilly's position that the Fallos' coverage had terminated.

In fact, even after the Fifth Circuit ruling in the Fallos' favor, Piccadilly continued to insist that the Fallos owed Piccadilly money in excess of the benefits owed by Piccadilly. At one point, Piccadilly even tried to flex its proverbial financial muscle by stating that "(Piccadilly) is willing to accept a dismissal of this action rather than pursue the amount of premiums owed."

Since no explanation of benefits was provided along with the affidavit, the Fallos inquired as to manner and method in which the dollar amounts contained in the plan administrator's analysis were reached. Piccadilly, however, needed time to determine how the analysis was reached, an analysis which Piccadilly then based its main defense – the same analysis included in an affidavit that was filed in the record before this Court as being true and correct. How could Piccadilly have sworn to the "truth" of the information contained therein and not know or have some written documentation showing the method and manner in which it reached the conclusions therein? This delay in providing information that should have been readily available only begins to show the frivolous nature in which Piccadilly has handled the Fallos' claims.

Piccadilly did not even abide by the terms of its own health plan which stated, in part, that:

> Any decision by the Plan Administrator shall be furnished to the Covered Person in writing and in a manner calculated to be understood by the Covered Person and shall set forth the specific reason(s) for the decision and the specific Plan provision(s) on which the decision is based.

The Fallos had never been provided with a proper explanation of benefits prior to January of 2001, but only provided with definitive, self-serving statements from Piccadilly regarding the premiums and benefits due. This is

hardly an acceptable, reasonable and "good faith" effort to resolve the matter, especially considering that the amounts originally sworn to by Piccadilly in its affidavit of May 5, 1997, continuously changed throughout the litigation. Whenever plaintiffs provided Piccadilly with further information, which Piccadilly itself could have obtained and should have obtained, and the claims administrator finds time to review the claims as she was originally required to do, the figures change in the Fallos' favor. In fact, the figures changed so drastically that they went from the Fallos owing Piccadilly money to Piccadilly settling the claim for over $45,000.

The Fallos had responded to extensive discovery propounded by Piccadilly, executed every medical authorization, Social Security Administration release and every other document requested by Piccadilly. A review of the record and the parties' submissions shows that Piccadilly was at least on notice as to the amounts of the claims, although Piccadilly took no steps to further investigate the claims by either requesting more complete submissions from the health care providers or the insured, more complete billing from the providers or the insured, complete hospital records, etc. Further, the initial submissions made by the Fallos, in the most part, contained proper coding, and should have resulted in the approval of over $30,000.00 in benefits.

At the very least, administrators relying on hospital records when determining whether a claim should be allowed under the plan obviously must review the most recent records. Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1016 (5th Cir. 1992). There is no justifiable basis for placing the burden solely on the administrator to generate evidence relevant to deciding the claim, which evidence may or may not be available to it. Vega v. National Life Insurance Services, 188 F.3d 287, 298 (5th Cir. 1999). The trial court held that Piccadilly was faced with incomplete information when making its denials. Plaintiffs provided the needed information, which delay is as much attributable to the Fallos as to Piccadilly. However, this decision by the trial court is tantamount to declining to hold an administrator to his duties and placing the burden solely on the claimant. Piccadilly went so far, at one point in the litigation, to state that "[t]his

ongoing intransigence and failure to comply with the terms of the statute and plan on the part of the plaintiffs is the reason why they have incurred fees and costs." The opposite is true, in this case. It is Piccadilly's ongoing intransigence and failure to comply with the terms of its own plan that have resulted in the lengthiness of this litigation as well as the largely avoidable incurrence of fees and costs.

The onus is not upon the claimant to provide proper and thorough documentation for an administrator to make a reasonable decision regarding a claim. Salley v. E. I. DuPont de Nemours & Co., 966 F.2d 1011, 1016 (5th Cir. 1992). The administrator's job is to ensure the claim is properly evaluated and not have to rely solely upon documentation provided by the claimant, as Piccadilly was doing before attempting to properly evaluate the claims. Although it is inappropriate and inefficient to require the administrator to obtain information in the absence of the claimant's active cooperation, such was not the case here.

A court must give deference to the administrator's decision. That the administrator decides a claim when conflicted, however, is a relevant factor. In a situation where the administrator is conflicted, the court should give less deference to the administrator's decision. In such cases, the court should be less likely to make forgiving inferences when confronted with a record that arguably does not support the administrator's decision. Although the administrator has no duty to contemplate arguments that could be made by the claimant, the administrator's decision must be based on evidence, even if disputable, that clearly supports the basis for its denial. Vega, 188 F.3d at 299. The district court did not consider possible bias of a conflicted administrator when denying these claims.

A district court, in most instances, is limited to the administrative record when it reviews an administrator's determination. As a result, the district court must inquire only whether the "record adequately supports the administrator's position"; from that inquiry it can conclude that the administrator abused its discretion if the administrator denied the claim without some concrete evidence in the administrative record. Gooden v. Provident

Life & Accident Insurance Co., 250 F.3d 329, 333 (5th Cir. 2001). Throughout its opinion, the district court continuously gave forgiving inferences to the blanket denials and the miscalculated premiums, ultimately holding Piccadilly's position throughout the many years of litigation as reasonable.

Piccadilly obviously failed to take any action or undertake any efforts to properly and timely review the claims submitted prior to the 5th Circuit ruling, as evidenced by its changing figures regarding both benefits and premiums due. At the very least, however, Piccadilly's actions since the 5th Circuit decision ruling that the Fallos were entitled to an additional 11 months of coverage border on "frivolous." Piccadilly's actions serve only one of three purposes: (1) to further delay the resolution of this matter; (2) to cause the incurrence of additional time and costs by plaintiffs' attorneys; or (3) operate to change the amounts due in premiums and benefits previously sworn to by Piccadilly.

Apparently, Piccadilly still had not thoroughly reviewed the claims because it could never itemize the amounts of the charges that are covered but merely indicated whether charges were eligible for coverage. In fact, plaintiffs can cite to at least six different documented premium calculations by Piccadilly throughout this litigation, which premium amounts were totally in Piccadilly's purview and control and never reliant upon any information obtained from a claimant:

5/5/97 affidavit of Jeanita K. Slaton:
Premiums due $5,598.68. Concluded that Fallos owed Piccadilly.

1/7/00 letter from Piccadilly:
Premiums due $4,688.00. Concluded that Fallos owed Piccadilly.

Handwritten analysis of Jeanita Slaton (date unknown): Premiums due $1,591.64.

Handwritten analysis of Jeanita Slaton (date unknown): Premiums due $4,007.04

8/21/00 letter from Piccadilly:
Premiums due $7,032.19. Concluded that Fallos owed

Piccadilly.

2/19/01 letter from Piccadilly:

Premiums due $6,894.72. Concluded that Piccadilly owed Fallos over $45,000.

However, not only has Piccadilly unreasonably delayed settlement of this matter, it has delayed litigation of this matter, in essence, delaying any of the Fallos hopes of resolution of this matter. For example, when given the opportunity to expedite this matter and have the case heard before a magistrate judge, Piccadilly refused, stating its reason for refusal being the trial judge's intimate familiarity with the matter. Ironically, the issues which remained unresolved did not require "intimate" knowledge of the case in that only extent of coverage and amount of premiums due need be decided. The only intimate knowledge needed was a logical interpretation of the claim covered by the Plan. These issues have never been presented nor briefed before any court, and petitioners respectfully submit that this was only a further delay tactic displayed by Piccadilly, a further abuse of discretion.

Although a two-year delay in the payment of benefits which were legally due resulted, the district court failed to see Piccadilly's bad faith, determined the initial denials to be reasonable as the legal issues were "close calls," and held that the delay was not unreasonable. Application of this factor involving the degree of culpability would deter other plaintiffs from bringing suits in close cases, thereby discouraging potentially meritorious actions.

2. *The ability of the losing party to satisfy an award of attorney's fees:*

This is perhaps the only factor that considers special circumstances that may exist which would make an award of attorney's fees unjust. This is also the only factor that applies fee-shifting principles to this fee-shifting provision. Interestingly, this factor also weighed in the Fallos' favor when the district court conducted its five-factor analysis.

3. Whether an award of attorney's fees against the losing party would deter others acting under similar circumstances:

Again, fee shifting becomes punitive with the application of this factor in that it is being employed to deter conduct. ERISA allows for compensatory damage awards apart from fee shifting under section 502(g)(1). Compensatory damages, along with the necessity of bearing one's own costs if a suit is brought, deter conduct violative of ERISA without being punitive. In fact, Piccadilly alleged that the litigation has already served a deterrent purpose, i.e., Piccadilly has changed its SPD to read more similarly to the Plan. However, that should not be a factor weighing against attorney's fees in this matter.

Additionally, the statute's punitive provisions and its strict fiduciary standard also deter such conduct. Because deterrence exists absent section 502(g)(1), using that section as a further deterrent only adds extra penalty for improper conduct. Neither punitive nor deterrent fee shifting is justified absent bad faith, and Congress did not intend that section 502(g)(1) be applied punitively.

An award of attorney's fees would deter other ERISA-plan sponsors from delaying proper payment of benefits. Again, at the very least, Piccadilly has been on notice that benefits are due to the Fallos since the May 29, 1998 judgment of the United States Fifth Circuit. At that time, Piccadilly already had voluminous medical records and properly coded billing statements. That judgment was rendered almost three years prior to settlement of the underlying claim for benefits in this matter.

If Piccadilly does not have to pay attorney's fees, it would only be liable for what it should have covered before this litigation commenced. With nothing to lose but its own litigation costs, other ERISA-plan sponsors might find it worthwhile to force underfinanced beneficiaries to sue them to gain their benefits or accept undervalued settlements. See National Companies Health Benefit Plan v. St. Joseph's Hospital of Atlanta, Inc. 929 F.2d 1558 (11th Cir. 1991). "An award of attorney's fees will serve as a deterrent and will encourage plan administrators not to shirk their

responsibilities in the claims review process." Roig v. Limited Long Term Disability Program, 2000 WL 1176522 (E.D. La. August 4, 2000).

***4. Whether the party requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or resolve a significant question regarding ERISA, itself*:**

This factor practically negates awarding attorney's fees to an individual who did not file a class action or declaratory judgment action. In fact, the district court's opinion cites the possibility of these two types of lawsuits as evidence that the Fallos did not seek to benefit all participants in Piccadilly's plan. Although they did not file a suit in the format that would have apparently weighed this factor in their favor, the Fallos' action did benefit all plan participants.

The Fallos detrimentally relied upon the Piccadilly-supplied language of the SPD when notifying Piccadilly of Kasey Fallo's disability which rendered her "unable to engage in virtually any occupation." It is also noteworthy that there is no definition of "disabled" or "disability" contained within the SPD.

The Fallos' detrimental reliance on the vague and ambiguous SPD is further demonstrated by the fact that they remitted premiums to Piccadilly after the initial eighteen (18) month period and during what should have been the eleven (11) month extended period. Piccadilly did not return the premium check until September 27, 1993. Piccadilly's retention of the insurance premium for nearly one month naturally led the Fallos to believe that coverage was extended in accordance with the SPD.

This litigation has benefitted all participants of the Piccadilly plan and resolved a significant legal question regarding the determination of disability and the extension of benefits as a result thereof. Piccadilly has already rewritten its SPD in a more clear and straightforward manner, so that all plan participants are able to fully understand their rights under the Plan.

Even if the Fallos had filed a class action suit or a declaratory judgment action, the automatic award of attorney's fees in such cases is inherently unfair. Consideration of the amount of benefit conferred on members of the pension plan as a whole resembles the common fund or common benefit doctrine. At equity, court may assess fees to a class that benefits from the litigation. Thus, if a common benefit results from an ERISA suit, courts can shift the cost of attorney's fees from the plaintiff to the benefitted class independent of ERISA's fee-shifting provision. Applying the common benefit doctrine reflects the statute's purpose and enables qualifying potential plaintiffs, regardless of their financial status, to bring ERISA actions. The five-factor test, however, treats the creation of a common benefit as an opportunity to shift fees to the defendant, resulting in unjust enrichment to the benefitted class. The common benefit rationale offers no justification for shifting a plaintiff's attorney's fees to a defendant.

5. The relative merits of the parties' positions:

Largely discussed under the bad faith/culpability factor discussion above, this factor also requires an inquiry into culpability which is totally improper under fee-shifting principles. Curiously, the trial court found the culpability factor to weigh in Piccadilly's favor, yet found that the relative merits of the Fallos' positions weighed in favor of an award.

VII. CONCLUSION

By not considering a presumption favoring an award of attorney's fees to a prevailing party, the Fifth Circuit's five-factor analysis has created a situation where a prevailing party, who settled the underlying claim, is prevented from recovering attorney's fees due to the inherent faults in that five-factor analysis. By concentrating on culpability more than fee-shifting principles, the five-factor test utilized alone, will result in a chilling effect to litigants whose claims may be close. It also discourages settlement practice, thereby

requiring an exhaustion of judicial resources in order to recover fees.

The purpose of this fee-shifting statute is to facilitate meritorious ERISA litigation that plaintiffs would not otherwise bring because of the cost of retaining an attorney. Courts should award attorney's fees to those plaintiffs who could not bring their action but for knowledge that if they won on the merits courts would award them fees. The court should compare the damage award to the amount of attorney's fees charged to the plaintiff. Courts should always grant a plaintiff's request for attorney's fees if the fee is equal to or greater than the damage award. The court should grant a party's request in close cases when it is difficult for the plaintiff to determine whether or not his damages would exceed his attorney's fees. This will prevent the five-factor test adopted by the Fifth Circuit from having a chilling effect on potential plaintiffs whose expected costs are close to their expected recovery. Courts should err on the side of allowing more ERISA plaintiffs to bring suit for fear that a meritorious claim would go unasserted if the case is close.

The inherent faulty analysis employed by the Fifth Circuit, utilizing five-factors that concentrate more on punitive principals and less on fee-shifting principles as well as its failure to apply a presumption in favor of awarding fees to a prevailing party, as employed by the Second, Eighth and Ninth Circuits, results in a chilling effect upon settlement of ERISA claims as well as the assertion of potentially meritorious claims when a close question is involved. This Court should resolve the disparities between the application of 29 USC §1132 (g)(1) by the various circuits and announce a uniform test for the federal circuit courts of appeals to apply when determining whether or not to award attorney's fees in ERISA actions.

THEREFORE, Petitioners, Scott Fallo and Kasey Fallo request of this Court that is GRANT their Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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(Any footnotes trail the end of each document.)
No. 01-31283

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

SCOTT FALLO; KASEY FALLO
Plaintiffs-Appellants,

v.

PICCADILLY CAFETERIAS, INC.; ET AL.,
Defendants,

PICCADILLY CAFETERIAS, INC.,
Defendants-Appellee.

May 1, 2002 filed

Appeal from the United States District Court
for the Eastern District of Louisiana
(94-CV-907-M)

Before HIGGINBOTHAM, WIENER, and BARKSDALE, Circuit Judges. PER CURIAM:*

Plaintiffs-Appellants Scott and Kasey Fallo appeal the district court's order denying their motion for attorney's fees and costs incurred in the instant Employment Retirement Income Security Act (ERISA) suit. The Fallos argue that the district court abused its discretion in denying the motion.

The district court, by adopting the magistrate judge's report and recommendation, determined that an award was unwarranted because, although Piccadilly had the ability to satisfy such an award, there was no indication that Piccadilly had acted in bad faith, that an award in the instant case would have a deterrent effect, and that the instant suit would benefit all participants of an ERISA plan or would resolve a significant ERISA question. The district court also reasoned

that Piccadilly's legal position was not so disproportionately meritless as to justify an award. After reviewing the record and the briefs of the parties, we cannot say that these findings are clearly erroneous or that they represent an abuse of discretion. Ramsey v. Colonial Life Ins. Co. of America,, 12 F.3d 472, 480 (5th Cir. 1994). Accordingly, the district court's order denying the Fallos' motion for attorney's fees and costs is AFFIRMED. id., Harms v. Cavenham Forest Industries, Inc., 984 F.2d 686, 694 (5th Cir. 1993)

AFFIRMED.

Footnotes

*Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

No. 94-907

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

SCOTT FALLO; KASEY FALLO
Plaintiffs-Appellants,

v.

PICCADILLY CAFETERIAS, INC.; ET AL.,
Defendants,

PICCADILLY CAFETERIAS, INC.,
Defendants-Appellee.

August 16, 2001 filed

FINDINGS AND RECOMMENDATION

I. FACTUAL AND PROCEDURAL BACKGROUND

Plaintiffs, Scott Fallo and his wife, Kasey Fallo, filed this action in state court against Mr. Fallo's former employer, Piccadilly Cafeterias, Inc. ("Piccadilly"). They claimed entitlement to extended health insurance benefits from Piccadilly under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and sought damages under the Americans with Disabilities Act. Piccadilly removed the case to this court on March 17, 1994 pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). 29 U.S.C. § 1001 et seq.

> Following the termination of Scott Fallo's employment with Piccadilly Cafeterias, Scott and Kasey Fallo attempted to extend their health insurance coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Piccadilly's Health Benefits Plan (the

> Plan) because of Kasey Fallo's disability. The district court denied the Fallos['] motion for summary judgment and granted Piccadilly's cross-motion for summary judgment, finding that the Fallos did not meet the requirements for this extended health insurance coverage. . .
>
> Scott Fallo ended his employment with Piccadilly in February 1992. Before leaving, he expressed his intention to extend health benefits under COBRA for an additional 18 months. During this period of continuation coverage, the Fallos paid their required premiums. In January 1993, Fallo's wife, Kasey, became pregnant. Kasey Fallo is a diabetic and her pregnancy was marked by serious complications. The 18 month period of continuation coverage was scheduled to end on August 25, 1993. On August 23, 1993, Scott Fallo's father, by certified mail, sent Piccadilly notice that Kasey Fallo was "disabled" by her pregnancy and that she relied upon her disability to extend further their health insurance benefits under COBRA. - . On September 8, 1993, Piccadilly responded that it would not extend coverage unless Kasey Fallo obtained a determination "that she is disabled for purposes of Social Security" within 60 days of August 25, the date that the initial extension of coverage ended. Piccadilly eventually denied coverage and this litigation ensued.
>
> While this suit was pending, Kasey Fallo applied to the Social Security Administration for a determination that she was disabled.

Fallo v. Piccadilly Cafeterias, Inc., 141 F.3d 580, 581-82 (5th Cir. 1998) (footnotes omitted).

The presiding district judge dismissed plaintiffs'

Americans with Disabilities Act claim on defendant's first motion for summary judgment on July 7, 1994. Record Doc. No. 16. On July 7, 1994 and March 17, 1995, the court denied Piccadilly's first and second motions for summary judgment, respectively, on the merits of plaintiffs' ERISA claim. Record Doc. Nos. 16, 27.

Because Mrs. Fallo's entitlement, if any, to extended health insurance coverage indisputably depended on a finding that she "is disabled for purposes of Social Security," this lawsuit was stayed on June 19, 1995 upon defendant's motion while the Social Security Administration considered Mrs. Fallo's application for disability benefits, which had been filed in April 1994. Record Doc. No. 32. The Social Security Administration denied Mrs. Fallo's application for disability benefits initially and on reconsideration. Defendant's Exh. S. She appealed and the Social Security Administration determined on November 27, 1996 that she had been disabled between March 1993 and October 1994. Defendant's Exh. W.

After that decision became final, this case was reopened on plaintiffs' motion on April 11, 1997. Record Doc. No. 37. Piccadilly continued to deny that plaintiffs were entitled to extended health insurance coverage. On July 29, 1997, the district judge denied plaintiffs' motion for summary judgment, granted Piccadilly's cross-motion for summary judgment and entered judgment for defendant. Record Doc. Nos. 43, 44.

The Fallos appealed to the Fifth Circuit, which reversed the grant of summary judgment and rendered judgment in favor of plaintiffs on the coverage issue on May 29, 1998. Record Doc. No. 46. The appeals court held that plaintiffs were entitled to rely on Piccadilly's Summary Plan Description of its health insurance plan, had complied with the requirements of the Summary Plan Description and were entitled to the 11 months of extended health insurance coverage they had requested. The Fifth Circuit remanded the case to this court to determine the amount of benefits that

Piccadilly owed to the Fallos and the amount of premiums that the Fallos owed to Piccadilly for the extended coverage.

The parties settled the benefits and premiums issues a few days before the scheduled trial and the district judge entered a 60-day order of dismissal on March 1, 2001. Record Doc. No. 55. Plaintiffs demanded attorney's fees and costs under ERISA but Piccadilly did not agree that they were entitled to any fees and costs. The presiding district judge referred the attorney's fees and costs issues to me for findings and recommendation. Record Doc. No. 56.

The Fallos filed a timely motion for attorney's fees and costs, supported by voluminous exhibits. Record Doc. No. 61. Defendant filed a timely opposition memorandum with equally voluminous exhibits. . Record Doc. No. 63. In its memorandum, Piccadilly requested that it be given the opportunity to submit evidence at a later date, if necessary, concerning its ability to pay an award of attorney's fees.

Accordingly, the court ordered Piccadilly to submit such evidence, Record Doc. No. 64, and Piccadilly did so, Record Doc. No. 66. Having reviewed the record, the submissions of the parties and the applicable law, and for the following reasons, IT IS RECOMMENDED that plaintiffs' motion be DENIED.

II. ANALYSIS

A. Standard for Awarding Attorney's Fees and Costs Under ERISA

It is well established that "a party need not prevail in order to be eligible for an award of attorneys' fees under § 1132(g)(1) of ERISA." Gibbs v. Gibbs 210 F.3d 491, 503 (5th Cir. 2000). "[T]he prevailing status of the parties is not determinative of the fee awards, though generally, a proper analysis of the five factors will in most instances favor an award of fees to the party which has most substantially prevailed." Id. at 504.

The determination of attorney's fees and costs in an ERISA case requires a two-step analysis. First, the court must determine whether the party is entitled to fees by applying the following analysis.

> Under ERISA, "the court in its discretion may allow a reasonable attorneys' fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). Such an award, as the statute states, is purely discretionary. ... The [Fifth Circuit] has generally required, however, that the following five factors [known as "the Bowen factors"] be considered in deciding whether to award attorneys' fees to a party under § 1132(g)(1):
>
> [A] court should consider such factors as the following: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorneys' fees; (3) whether an award of attorneys' fees against the opposing party would deter other persons acting under similar circumstances; (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' position.
>
> While other circuits have asserted that a presumption exists under ERISA in favor of awarding costs and attorneys' fees, that is not the law in ... this Circuit.

Todd v. AIG Life Ins. Co., 47 F.3d 1448, 1458-59 (5th Cir. 1995). (citing Harms v. Cavenham Forest Indus. Inc., 984 F.2d 686, 694 (5th Cir. 1993); Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1016 (5th Cir. 1992); Iron Workers Local No. 272 v. Bowen 624 F.2d 1255, 1266 (5th Cir. 1980)). "No one of these factors is necessarily decisive, and some may not

be apropos in a given case, but together they are the nuclei of concerns that a court should address in applying section 502(g)." Bowen, 624 F.2d at 1266.

Second, if the court determines that a party is entitled to an award of attorney's fees, the court must apply the "lodestar" method to calculate the reasonable amount to be awarded. Todd, 47 F.3d at 1459.

Analysis of the five factors in the instant case presents a painfully close question. On balance, however, I find that the factors weigh in favor of Piccadilly and that plaintiffs' motion for attorney's fees should be denied for the following reasons.

B. Piccadilly Did Not Act in Bad Faith

Plaintiffs argue that Piccadilly acted in bad faith from the date that it first denied coverage and continuing throughout this litigation. As evidence of the alleged bad faith, plaintiffs contend that Piccadilly consistently denied coverage until after the Fifth Circuit ruled and that its rationale for denial of coverage kept changing: Piccadilly's calculations of premiums owed and benefits due also kept changing: Piccadilly had a duty, which it neglected, to gather the medical records and invoices that proved the amount of plaintiffs' claim; and, had Piccadilly gathered the medical records, it would have known that the Social Security Administration would "inevitably" find Mrs. Fallo disabled.

Based upon a thorough review of the arguments and evidence submitted, I find that plaintiffs' allegations of bad faith are unfounded. First, Piccadilly consistently and continually refused the Fallos extended coverage based on the language of the Plan, and the presiding district judge granted summary judgment to Piccadilly based on that language. The Fifth Circuit confirmed that the Plan contained the language on which Piccadilly relied. Fallo, 141 F.3d at 583 ("Both the Plan and COBRA contemplate that the qualified beneficiary will provide notice of the Social Security

disability finding before the expiration of the initial 18 month period of extended benefits,"). Neither the Fifth Circuit nor the presiding district judge made any finding that Piccadilly acted in bad faith by relying on the terms of the Plan to deny coverage.

However, the Fifth Circuit found that Piccadilly's Summary Plan Description conflicted with the language of the Plan itself.

> Unlike the language of the Plan and COBRA, this provision does not state that the qualified beneficiary must send notice of a Social Security Administration disability finding before the end of the initial 18 month extension, nor does the SPD [Summary Plan Description] state that the disability must exist at the time of the qualifying event such as the termination of employment. In a case of conflict such as this, where the requirements of the SPD are more lenient than those contained in the Plan, the SPD is controlling.

Id. at 584. Thus, until the Fifth Circuit ruled, Piccadilly had been consistent, and successful in the district court, in its refusal to extend coverage. While the Fifth Circuit ultimately found Piccadilly's legal position to be incorrect, that does not equate to a finding of bad faith.

The evidence submitted by the parties negates plaintiffs' assertion that Piccadilly's rationale for denying coverage "kept changing." By letter dated September 8, 1993, Piccadilly explained that it denied coverage, inter alia, because Mrs. Fallo establish that she is 'disabled' under the definitions of the Social Security Act" and she "has 60 days from the date of expiration of coverage to establish that she is disabled for purposes of Social Security." Plaintiffs' Exh. A at p.2. On September 27, 1993, Piccadilly returned plaintiffs' check for the premium for extended coverage, for the reasons explained in the September 8, 1993 letter. Plaintiffs'

Exh. B.

In its original motion for summary judgment filed on April 4, 1994, defendant argued that it could not be liable under the terms of its plan because of plaintiffs' failure to notify it of any disability within the 18-month period of extended coverage, or to notify it of any determination of disability by the Social Security Administration. Defendant's Exh. A, at pp. 10-11. In its reurged motion for summary judgment on January 10, 1995, Piccadilly again argued that Mrs. Fallo was required to provide it with notice of a determination of Social Security disability prior to the expiration of the 18-mouth period of extended coverage and that she still bad not provided such notice. Defendant's Exh. O, at p.6. Thus, contrary to plaintiffs' contention, defendant did not raise this argument for the first time after plaintiffs obtained a Social Security disability determination.

This case is completely unlike Wegner v. Standard Ins. Co., 129 F.3d 814(5th Cir. 1997), which plaintiffs cite in support of their argument that Piccadilly acted in bad faith. In Wegner, the district court found that defendant's "attempt to support its [disability] benefit calculation via a [salary] Change Authorization form that was executed after Wegner became disabled 'bordered on the frivolous, " and the Fifth Circuit held that defendant's contentions "evidence[] a lack of credibility on Standard's part, and convince[ ] us that the above argument is nothing but a post hoc attempt to justify what was an otherwise proscribed use of the Change Authorization form," thus justifying the district court's weighing of such behavior against defendant. Id. at 821. Standard's conduct in Wegner was bad faith because it was not based on any reasonable use of the evidence, while Piccadilly's conduct was based on a reasonable, although ultimately unsuccessful, interpretation of the Plan.

Piccadilly's motion for a stay in mid-1995 pending the outcome of a Social Security disability determination does not evidence bad faith. Both the Plan and the Summary Plan Description required Mrs. Fallo to obtain such a

determination before coverage could be extended. A denial of Social Security disability benefits would clearly terminate this lawsuit in Piccadilly's favor. "Because the Social Security Administration's decision could be dispositive of the outcome of this suit, the district court granted the stay." Fallo, 141 F.3d at 582. Therefore, the stay served judicial economy and the convenience of the parties. It is unpersuasive of plaintiffs to suggest, as evidence of Piccadilly's bad faith, that Piccadilly "should have known or at least been on notice of the inevitable conclusion" that the Social Security Administration would find Mrs. Fallo disabled, Memorandum in Support of Motion for Attorney's Fees and Costs, Record Doc. No. 61 at p.7, when the Social Security Administration denied her application both initially and upon reconsideration, and only found her disabled after a hearing before an administrative law judge. Defendant's Exh. S, Mar. 24, 1995 Social Security Administration decision denying benefits; Defendant's Exh. W, Nov. 27, 1996 Social Security Administration decision finding disability.

Finally, Piccadilly's neglect of its alleged duty to gather medical records and invoices to support plaintiffs' claims does not evidence bad faith either factually or legally. First, so long as Piccadilly denied that Mrs. Fallo was covered at all, it had no reason to collect medical records and to calculate benefits that it denied were due. That would have been a futile exercise.

Second, the Fifth Circuit has squarely held that an administrator "is not under a duty to 'reasonably investigate' a claim because it would be 'not only inappropriate but inefficient to require the administrator to obtain [] information [in the claimants control] in the absence of the claimant's active cooperation.'" Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329,333(5th Cir. 2001) (quoting Vega V. National Life Ins. Servs., Inc., 188 F.3d 287,298(5th Cir. 1999) (en banc)) (emphasis added); accord Roig v. Limited Long Term Disability Program, No. 99-2460, 2000 WL 1146522, at *14 (E.D. La. Aug. 4, 2000) (Vance, J.).

The Fallos cite Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1015(5th Cir. 1992). for the proposition that a plan administrator has a duty to investigate and gather medical records. The en banc Fifth Circuit in Vega specifically held that Salley did not impose any such general duty. Vega 188 F.3d at 298. Rather, it is the claimant's duty in the first instance to supply the administrator with evidence to substantiate her claims because the evidence is more readily accessible to the claimant and such a rule encourages claimants to provide all relevant evidence to the administrator in order to resolve disputes at that level. Id. at 298, 300; accord Gooden 250 F.3d at 334 n.7, 335.

After the Fifth Circuit ruled that plaintiffs were entitled to coverage, Piccadilly cooperated with plaintiffs in reviewing the medical evidence to determine the amount of plaintiffs' valid claims under the Plan. This process was lengthy, as plaintiffs gathered and submitted to Piccadilly medical records and invoices that were then more than five years old, some of which had to be reconstructed by the health care providers. It was during this time period that Piccadilly's calculation of the amounts due to plaintiffs "kept changing," as plaintiffs allege. Changes occurred as plaintiffs submitted previously unaccounted-for records, and the administrator reviewed them for eligibility and took them into account in its calculations. Piccadilly also admittedly corrected prior errors in calculations. The delays in reaching final figures were attributable at least as much to plaintiffs as to defendant.

The Fallos point to the changes in calculated benefits due since May 5, 1997, when Piccadilly submitted with one of its motions for summary judgment an affidavit by Jeanita K. Slaton, Piccadilly's employee benefits administrator. The affidavit asserted that, if Piccadilly were required to extend the requested coverage, the amount of premiums due from the Fallos as of that date for the 11-mouth extension would be approximately $5,500, which would exceed the amount of benefits due to plaintiffs by approximately $2,700, based on the medical claims that had so far been submitted. As noted

above, complete medical evidence and invoices were not submitted by plaintiffs until long after the Fifth Circuit ruled in 1998; the correspondence between the parties indicates that final figures were not reached until February 2001. Thus, the 1997 calculation does not evidence bad faith by Piccadilly.

The Fallos also point to Piccadilly's changing calculations of the amount of premiums owed by the Fallos to Piccadilly. Again, these changes do not demonstrate bad faith, but only reflect changes based on additional information received over the course of this litigation, simple errors in calculation and defendant's offer to reduce the premiums during settlement negotiations. Defendant's Exhs. VV, YY, ZZ.

The absence of bad faith by Piccadilly weighs in favor of denying plaintiffs request for attorney's fees and costs.

C. Piccadilly's Ability to Satisfy an Award of Attorneys' Fees

Neither party initially submitted any evidence of defendant's ability to pay an award of attorney's fees, although Piccadilly requested that it be given the opportunity to submit evidence at a later date, if necessary. After the court ordered Piccadilly to file such evidence, it submitted the affidavit of W. Scott Bozzell, who is its Executive Vice President, Secretary and Controller. Record Doc. No. 66.

Bozzell avers that Piccadilly has experienced declining sales for the past three years and, more importantly, has suffered a decline in net income from $7.9 million in the year ended June 30, 1999 to a net loss of $27.9 million for the 12 months ended March 31, 2001. In May 2001, Piccadilly announced that it was in default of its Senior Credit Facility. However, it reached an agreement with its lenders in June that waived the default. Piccadilly's cash balances have decreased from $4.4 million on March 31, 2001 to approximately $2 million on June 30, 2001. Id.

Plaintiffs' assertion that Piccadilly could pay their attorney's fees and costs out of the interest it collected while it withheld moneys owed to them is unpersuasive, as the monetary settlement between the parties included payment of prejudgment interest. Plaintiffs' Exh. H; Defendant's Exh. ZZ However, despite Piccadilly's income losses and declining each balance, it does not appear unable to pay a reasonable attorney's fee in this matter. Accordingly, this factor weighs in favor of plaintiffs.

D. An Award of Attorneys' Fees Would Not Serve a Deterrence Purpose

Given my finding that Piccadilly did not act in bad faith in refusing coverage, conducting this litigation or calculating benefits and premiums, there is no similar conduct to be deterred. Piccadilly's mere legal error in its interpretation of the Plan, an interpretation the presiding district judge in this court accepted and which was not declared erroneous until the Fifth Circuit ruled, is not the type of conduct that this factor is designed to deter. The Fifth Circuit recently explained that

> this factor was intended to be used, as a shield, to protect beneficiaries from the fear of having to pay to pursue an important ERISA claim in the event of failing to prevail. Clearly, Congress intended the fee provisions of ERISA to encourage beneficiaries to assert their rights without fear of being responsible for the fees and costs of their opponent's attorneys if they failed to prevail.

Gibbs, 210 F.3d at 505. That purpose has been accomplished here, as the Fallos have successfully asserted their rights. A fee award to them would not further this purpose.

Piccadilly admits that this litigation itself has already served a deterrent purpose. Piccadilly has revised its Summary Plan Description both in accordance with changes

in the law and, presumably, as a result of this litigation. Memorandum in Opposition to Plaintiffs' Motion for Attorney's Fees and Costs, Record Doc. No. 63, at p.23. Further, a fee award does not serve a deterrent purpose when "Plan administrators merely chose to interpret [a legal] document in the way they found correct." Dial v. NFL Player Supplemental Disability Plan, 174 F.3d 606, 614 (5th Cir. 1999). The presiding district judge agreed with their interpretation.

This factor weighs against granting plaintiffs' motion for attorney's fees and costs.

E. Plaintiffs Did Not Seek to Benefit All Beneficiaries of an ERISA Plan or to Resolve a Significant Legal Question Regarding ERISA Itself

Plaintiffs did not seek, through this lawsuit, to benefit all beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself. Rather, they sought only to receive extended coverage for Mrs. Fallo's disability. They sought neither declaratory nor injunctive relief, nor did they file a class action, either of which would have indicated their intent to benefit other Plan participants or beneficiaries.

This factor also weighs against plaintiffs' motion.

F. The Relative Merits of the Parties' Positions

As indicated by the presiding district judge's grant of summary judgment in favor of Piccadilly and the Fifth Circuit's conclusion that the Plan contained the language on which Piccadilly relied, defendant's position was not "so disproportionately meritless as to justify the imposition of an award of attorneys' fees to [plaintiffs] based on this factor," Gibbs, 210 F.3d at 505, nor were the relative merits "lopsidedly in favor of plaintiff." Roig, 2000 WL at *16. Thus, the Fifth Circuits judgment in favor of plaintiffs and their successful settlement weigh only slightly in favor of granting

their motion.

CONCLUSION

In summary, the first, third and fourth Bowen factors weigh in favor of defendant, while the second and fifth factors weigh only slightly in favor of plaintiffs. While the question is close and the result somewhat surprising and even discomforting given the tortured case history plaintiffs have endured to arrive at this point, I find that strict application of the governing law indicates that the court in its discretion should deny plaintiffs' motion for attorney's fees and costs.

RECOMMENDATION

For all of the foregoing reasons, it is RECOMMENDED that plaintiffs' motion for attorney's fees and costs be DENIED.

New Orleans, Louisiana,
This 16th day of August, 2001.

JOSEPH C. WILKINSON, JR.
UNITED STATES MAGISTRATE JUDGE

No. 94-907

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

SCOTT FALLO; KASEY FALLO
Plaintiffs-Appellants,

v.

PICCADILLY CAFETERIAS, INC.; ET AL.,
Defendants,

PICCADILLY CAFETERIAS, INC.,
Defendants-Appellee.

ORDER

The Court, having considered the Report and Recommendation of the Magistrate Judge, and the memoranda filed by both parties in connection therewith, hereby approves the Report and Recommendation of the Magistrate Judge and adopts it as the Court's opinion in this matter. Accordingly,

IT IS ORDERED that plaintiffs' Motion for Attorney's Fees and Costs is DENIED.

New Orleans, Louisiana,
This 26th day of September, 2001.

Peter Beer
United States District Judge